STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/16/2014			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE (EACH CORRECTION SHOULD BE (EACH		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010000	State Licensure State Indiana State accordance with Survey Date: 10 Facility Number Provider Number AIM Number: 1 Surveyors: Brett Code Specialist At this Life Safe Shore Health & Indiana Indiana Participation in MCFR Subpart 483 Fire and the 2000 Fire Protection A Life Safety Code Existing Health (410 IAC 16.2). This one story fabasement was de (222) construction sprinklered. The	e: 000369 r: 155530 00275190 t Overmyer, Life Safety ty Code survey, South Rehabilitation was found re with Requirements for Medicare/Medicaid, 42 3.70(a), Life Safety from 0 edition of the National Association (NFPA) 101, re (LSC), Chapter 19, Care Occupancies and recility with a partial retermined to be of Type II	K01	0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000369

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AND PLAN OF CORRECTION IDI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		NSTRUCTION 01	(X3) DATE S COMPL	ETED
		155530	B. WING			10/16/	2014
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		353 TYL	DDRESS, CITY, STATE, ZIP CODE ER ST N 46402		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē.	(X5) COMPLETION DATE
K010018 SS=C	including the corcorridors, and bath detectors in the race of the facility has a census of 69 at the Quality Review by Safety Code Special All areas where the customary access areas providing face of the sprinklered exception the back used. NFPA 101 LIFE SAFETY CODOORS protecting of the the sprinklered exception in the protection of the sprinklered exception of the sprinklered exception in the sprinklered exception in the sprinklered exception of the sprinklered exception in the sprinklered exception of the sprinklered exception of the sprinklered exception in the sprinklered exception of the sprinklered exception o	ridors, areas open to the ttery operated smoke esident sleeping rooms. It capacity of 129 with a me time of the survey. The property of 128/14. The residents have so were sprinklered. All facility services were put for the wooden shed for maintenance storage. DE STANDARD orridor openings in other osures of vertical chazardous areas are such as those constructed onded core wood, or g fire for at least 20 sprinklered buildings are sist the passage of		IAG	Barciaci		DATE
	closing of the door with a means suita	to impediment to the rs. Doors are provided able for keeping the door presenting 19.3.6.3.6 are 6.3					
	Based on observation facility failed to	prohibited by CMS ealth care facilities. ation and interview, the ensure 1 of more than rs were free from	K0100	018	The facility will ensure that resident room doors latch into their frames. Resident room didentified during the survey has		11/15/2014

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C5M621 Facility ID: 000369

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	onstruction 01	(X3) DATE SURVEY COMPLETED	
AND LUAIN	c. coldection	155530	A. BUILDING	<u> </u>	10/16/2014
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		353 TYI		
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER	GARY,	IN 46402	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1/10		closing. This deficient	IAU	been repaired All other reside	
	-	visitors, staff and 13		doors in the facility have been	
	residents on the 2			checked to ensure proper functioning No new issues	
				noted. Environmental Directo	
	Findings Include	n:		designee will check all doors in	n
		yr ea a		the facility to ensure proper functioning. Audits for door	
	Based on observa			latches will be conducted at le	ast
	maintenance dire	ector on 10/16/14 .m. and 3:00 p.m., the		weekly to ensure continued proper functioning. Results of	
		.m. and 3:00 p.m., the		weekly audits will be reported	to
		ism for the door which		the QA Team at least monthly	or
	did not latch into			until problem is considered resolved. Problem will be	
Maintenance Director acknowledged the				considered resolved when no	
	aforementioned of	_		new issues are identified over two month period.	а
				wo monur periou.	
	3.1-19(b)				
K010029	NFPA 101				
SS=F	LIFE SAFETY CO				
		d construction (with ¾ ors) or an approved			
	automatic fire extir	nguishing system in			
		s.4.1 and/or 19.3.5.4 s areas. When the			
		is areas. When the tic fire extinguishing			
	system option is us	sed, the areas are			
		her spaces by smoke and doors. Doors are			
	self-closing and no	on-rated or field-applied			
		hat do not exceed 48			
	permitted. 19.3.	ottom of the door are 2.1			
	•	ation and interview, the	K010029	The facility will ensure that	11/15/2014
		ensure doors to 2 of 2		hazardous storage area have	self

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED		
		155530	B. WING			10/16/	2014	
			p. Wate	_	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	L.		353 TYL				
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER			IN 46402			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	hazardous storag	ge rooms self closed to			closing mechanism on the doo			
	prevent the passa	age of smoke. This			The two rooms identified have			
	deficient practice	e could affect visitors,			had self closing mechanism installed to prevent the spread	of		
	_	nore residents in the Unit			smoke during a fire All other	OI		
	4 and small dinir				storage areas have been			
	compartments.	ig room smoke			checked to ensure that self			
	Findings include	:			closing mechanisms are in pla and functional. No new issues identified. Environmental Dire	3		
	2				or designee will audit doors at			
	Based on observation with the maintenance director on 10/16/14 between 11:00 a.m. and 3:00 p.m., door				least monthly to ensure proper			
					functioning. Results of audits			
					be reported to the QA Team at			
	closures were not provided for doors to				least monthly or until this proble is considered resolved. Proble			
		•			will be considered resolved aft			
		nd 406 which were being			two consecutive months of no	01		
		contained plastics,			new issues noted.			
	paper, several 5	gal buckets of acrylic						
	based paint, card	lboard, Styrofoam						
	products and 8 b	ags of Kingsford						
	Charcoal briquet	te. The maintenance						
	•	ledged at the time of						
		door closures were						
	•	door crosures were						
	missing.							
	3.1-19(b)							
K010038	NFPA 101							
SS=E	LIFE SAFETY CO	_						
		anged so that exits are						
	•	at all times in accordance						
	with section 7.1.	19.2.1	17017	2020	The facility will ensure that all	ovit	11/17/2014	
		ation and interview, the	K010	JU38	The facility will ensure that all doors are accessible at all time		11/15/2014	
		ensure two doors in 1 of			The exit doors identified during	_		
	1 locked emerge	ncy exits were accessible			The extraction identified during	7		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	A. BUILDING 01		COMPLETED	
		155530	A. BUI B. WIN			10/16/2014	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R		353 TYI			
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
					11 10 10 2		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	(X5)		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG				IAG	the survey have been repaired		
		C 7.1.10.1 requires a			Doors are easily opened without		
	_	shall be continuously			effort. All exits have been		
		of all obstructions or			checked to ensure proper		
	_	full and instant use in			functioning. All doors are		
		her emergency. This			functioning properly. Environmental Director or		
		e would affect all			designee will audit doors at lea	ast	
	residents, visitor	rs and staff that reside in			weekly to ensure continued		
	the Unit 4 wing.				proper functioning. Results of		
					audits will be reported to the C		
	Findings include	e:			Team monthly or until problem		
					considered resolved to ensure continue compliance. Problem		
	Based on observ	ration and interview with			will be considered		
	the maintenance	director on 10/16/14			resolved after two months of		
		.m. and 3:00 p.m., the			audits with no new issues note	ed.	
		ector attempted to open					
		end egress exit double					
		tenance director had to					
		pen the one side of the					
		side of the door was not					
	able to be opene						
		ector then had to slam the					
		attempts to get the door					
		lose properly. The					
	maintenance dire	ector acknowledged the					
	aforementioned	deficiency.					
	3.1-19(b)						
K010044	NFPA 101						
SS=F	LIFE SAFETY CC	DDE STANDARD					
		used, are in accordance					
	with 7.2.4. 19.2	2.5					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155530	B. WING		10/16/2014
NAME OF I	DROVIDED OD GUDDI IEI		STREE	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEI	K	353 T	YLER ST	
	_	REHABILITATION CENTER	GAR\	Y, IN 46402	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		vation and interview, the	K010044	The facility will ensure that fire doors latch into the door frame	11/10/201
	1	ensure 2 of 4 fire door		needed. The two doors identi	
		into the door frame.		during the survey have been	
		equires openings in the		repaired. Subsequent audits	
		otected by fire door		have shown that the doors are	
		pped with door closures		working properly. All fire door have been checked and adjust	
		7.2.1.8. NFPA 80, the		for efficiency and effectivenes	
		e Doors and Fire		smoke barriers. Environment	
		1.2 requires fire door		Director or designee will ensu	re
	assemblies to in	clude latches. NFPA 80,		proper functioning of smoke doors during monthly fire drills	
	2-1.4 requires al	Il fire doors to be closed		which would occur at least twi	
	and latched at th	ne time of a fire. This		month. The results of fire drill	
	deficient practic	e affects any resident,		will be reported to the QA Tea	
	visitor, and staff	f using the Units 2 & 3		at least monthly. This will be	
	and the Main Di	ining room		on-going QA monitoring issue	
	Findings include	e:			
	1) Based on obs	ervation and interview on			
	10/16/14 betwee	en 11:00 a.m. and 3:00			
	p.m. with the ma	aintenance director, the			
	fire door with a	1 ½ hour fire resistance			
	rating and separa	rated the existing Unit 2			
		Iain Dining Room, which			
		atching mechanism for the			
	^	to latch into the frame.			
	2) the fire door v	with a 1 ½ hour fire			
		g and separated the			
	_	Hall from the Main			
	_	which had a positive			
		nism for the door but			
		nto the frame. This was			
		naintenance director at			
	the time of obse				
	ine time of oose	i vation.	1		

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155530	B. WING		10/16/2014		
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE			
SOUTH	SHORE HEALTH &	REHABILITATION CENTER	353 TYLER ST GARY, IN 46402				
				II +0+02	(1/5)		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
		,					
	3.1-19(b)						
	3.1 17(0)						
K010046	NFPA 101						
SS=C	LIFE SAFETY CC						
		ng of at least 1½ hour					
	19.2.9.1.	ed in accordance with 7.9.					
		vation, record review and	K010046	The facility will ensure that	11/15/2014		
		cility failed to provide	1010010	documentation is available to	11/13/2011		
		entation of 30 second		show testing of the smoke			
		at 30 day intervals and		detectors throughout the facilit All smoke detectors have beer			
	ı ^	or 1 1/2 hours for 21 of 21		inspected and are fully	1		
		emergency lighting		functional. Testing of the			
		9.3 requires a functional		detectors was completed durir	ıg 📗		
		_		survey. One was found not to			
		ducted on every required		be working properly and was replaced during the survey.			
		emergency lighting		Environmental Director or			
	1 -	intervals for not less and an annual test shall		designee will conduct testing of	of		
				the smoke detectors at least			
		r not less than 1 1/2		weekly. Batteries will be repla	ced		
	hours. Written r			throughout the facility on 10/31/2015 per policy. Result:	s of		
		tests shall be kept. This		audits will be reported to QA			
	1	e could affect all		Team at least monthly on an			
	occupants.			on-going basis. The facility v	vill		
	E. 1			ensure that testing of battery operated lights is conducted for	or		
	Findings include	· ·		1/1/2 hours at least annually.			
		,		system was recently tested du	ring		
		ration, record review and		a power outage on 10/31/2014			
		en 11:00 a.m. and 3:00		and during routine testing. The power outage lasted for 3 hours			
	_	4 with the maintenance		and emergency lighting was	3		
	director: the fac	ility could not produce		engaged during the entire			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		155530	B. WING		10/16/2014	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
SOUTH	SHORE HEALTH &	REHABILITATION CENTER	353 TYLER ST GARY, IN 46402			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
	documentation to back-up lights ha monthly basis an documentation fo test. They mainte	o show the battery ad been inspected on a ad could not produce the or the 11/2 hour yearly		process. Environmental Direct documented testing of the lighting during the power outage. The QA Team will review testing intervals at least monthly or unproblem is considered resolved. Problem will be considered resolved when no new issues identified within a two month period.	ge. ng ntil d.	
K010052 SS=C	installed, tested, a accordance with N Code and NFPA 7 approved mainten complying with ap NFPA 70 and 72. Based on observinterview; the fact there was docum of 49 of 49 batte detectors. LSC 9 National Fire Ala 7-3.2 requires fir such as smoke deannually. NFPA station detectors one- and two fam be tested and may with Chapter 7.7	n required for life safety is nd maintained in IFPA 70 National Electrical '2. The system has an ance and testing program plicable requirements of	K010052	The facility will ensure that documentation is available to show testing of the smoke detectors throughout the facilit All smoke detectors have beer inspected and are fully functional. Testing of the detectors was completed durin survey. One was found not to be working properly and was replaced during the survey. Environmental Director or designee will conduct testing of the smoke detectors at least weekly. Batteries will be replat throughout the facility on 10/31/2015 per policy and dur routine testing. Results of auc	ng of aced ing	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	A. BUI	LDING	01	(X3) DATE COMPL 10/16/	ETED
		100000	B. WIN			10/10/	2014
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
SUITH	SHODE HEALTH &	REHABILITATION CENTER		353 TYI	IN 46402		
					114 +0+02		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	and visitors in th	· · · · · · · · · · · · · · · · · · ·		1710	will be reported to QA Team a	t	DATE
	and visitors in th	le facility.			least monthly on an on-going		
	Findings include:				basis.		
	Rased on observ	ation, record review and					
		facility's Fire and Safety					
		4 between 11:00 a.m.					
		with the maintenance					
	_						
	director; the annual fire alarm system inspection report by a third party vendor dated 07/24/14 did not include the testing						
	of battery operated smoke detectors.						
		with the maintenance					
	•	ght the 3rd party vendor					
	•	system was doing the					
		e never documented his					
	inspection, so lie						
	_						
		smoke detectors. The ector acknowledged there					
		atation available to show					
	when the battery	hecked and when the					
		placed on all forty nine					
	smoke detectors.	•					
	2 1 10(1)						
	3-1.19(b)						
1/040054	NEDA 464						
K010054 SS=E	NFPA 101 LIFE SAFETY CO	NDE STANDARD					
33-E		e detectors, including					
	·	oor hold-open devices, are					
		ned, inspected and tested					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETED			ETED	
		155530	B. WIN			10/16/	2014
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	C		353 TY	LER ST		
	SOUTH SHORE HEALTH & REHABILITATION CENTER				IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		h the manufacturer's		TAG	DEFICIENCE		DATE
		9.6.1.3					
	-	ration, record review and	K01	0054	The facility will ensure that		11/15/2014
		cility failed to ensure 1	IXO	1005-1	documentation is available to		11/13/2014
	-	ctors had been replaced			show testing of the smoke		
		•			detectors throughout the facilit		
	•	C Section 9.6.1.3 says the			All smoke detectors have beer inspected and are fully	ח	
	provisions of 9.6				functional. Testing of the		
		fire alarm system,			detectors was completed durir	ng	
	•	tection systems. LSC			survey. One was found to not		
		NFPA 72, National Fire			working properly and was		
		FPA 72, at 7-3.2.1.			replaced during the survey. Environmental Director or		
	Detectors found	to have sensitivity			designee will conduct testing of	nf.	
	outside the listed	d and marked sensitivity			the smoke detectors at least	21	
	range shall be cl	eaned and recalibrated or			weekly. Batteries will be repla	ced	
	replaced. This d	leficient practice affects			throughout the facility on		
	any resident, sta	ff or visitor using the			10/31/2015 per policy or during		
	small dining roo	m.			routine testing. Results of aud will be reported to QA Team a		
					least monthly on an on-going	ι	
	Findings include	::			basis.		
	Based on observ	ration, record review and					
		en 11:00 a.m. and 12:00					
	p.m. on 10/16/14	4, with the maintenance					
	*	third party vendor report					
		and titled "sensitivity					
		oke detector located in the					
	_	m was found outside the					
	_	ed sensitivity range and					
		the sensitivity testing.					
		e director acknowledged					
		etector failed and said at					
		d review, he had no					
		tion to provide to show					
	the smoke detect	tor had been repaired or					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 01 COMPLI				
		155530	B. WIN			10/16/	2014
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K010068 SS=D	replaced. 3.1-19(b) NFPA 101 LIFE SAFETY CO Combustion and v incinerator and he and discharged to Based on observer facility failed to rooms was provict combustion air for rooms containing accordance with This deficient pro atmosphere rich which could cause staff in the basen. Findings include Based on an observer which could cause staff in the basen. Findings include Based on an observer which could cause staff in the basen. Findings include Based on an observer which could cause staff in the basen. Findings include Based on an observer which could cause staff in the basen. Findings include This was acknown.	DE STANDARD entilation air for boiler, ater rooms is taken from the outside air. 19.5.2.2 ation and interview, the ensure 1 of 1 laundry ded with intake rom the outside for g fuel fired equipment in LSC Section 19.5.2.2. actice could create an with carbon monoxide se physical problems for nent. : ervation and interview ance director on in 11:00 a.m. and 3:00 int laundry room had 2 with no fresh air intake.	K01	0068	The facility will ensure that the laundry area has adequate fre air intake. Upon observation, noted that fresh in-take is available in the laundry area. Access has been restored. Carbon Monoxide detectors ar place for safety. No other area identified in the facility that wo present this type of problem. In-service conducted with laundry employees to ensuthat fresh air flow is not blocke the future. Environmental Director or designee will monit fresh air intake at least weekly ensure continued compliance. Results of audits will be report to the QA Team on a monthly basis or until problem is considered resolved. Problem will be considered resolved who new issues are identified for two consecutive months.	sh it is re in as uld ure d in or to ed	11/15/2014

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/16/2014		
SOUTH	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K010069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, record review and interview, the facility failed to ensure fire extinguishing equipment for 1 of 1 range hoods was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire-actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice affects occupants of the kitchen where 3	K010069	The facility will ensure that fire suppression system is inspect at least every six months. Northern Fire Equipment Corporation will be at the facil to inspect the system on 10/07/2014 Completed with n new issues. No other fire suppression systems are loca in the facility. The Environme Director or designee will ensu that the system is inspected e 6 months. Northern Fire Equipment has placed the fac on an every 6 month rotation of the ensure continued compliance. Results of inspection will be reported to the QA Team on a on-going basis	ity o ted intal re very ility		

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PRINTED: 11/25/2014 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		A. BUI	LDING	01	COMPLI		
100000			B. WIN			10/16/	2014
NAME OF P	ROVIDER OR SUPPLIER			353 TYI	ADDRESS, CITY, STATE, ZIP CODE		
SOUTH SHORE HEALTH & REHABILITATION CENTER					IN 46402		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCT		DATE
	staff were observ	rea.					
	Findings include:						
	Based on a obser	vation, record review					
		tween 11:00 a.m. and					
	3:00 p.m., on 10/						
	-	ector: the facility had no					
		show the Engineered					
	Restaurant Fire S	Suppression System had					
	been recently inspected. The						
		ector also stated that he					
	had no record or recalled if the past six month inspection was conducted. The						
	maintenance director acknowledged the aforementioned deficiencies. 3.1-19(b)						
K010074	NFPA 101						
SS=E	LIFE SAFETY CO	DE STANDARD s, including cubicle					
		r loosely hanging fabrics					
	and films serving a	as furnishings or					
		of 10.3.1 and					
		n provisions of 10.3.1 and rds for the Installation of					
	Sprinkler Systems	. Shower curtains are in					
	accordance with N	IFPA 701.					
	Newly introduced	upholstered furniture					

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PRINTED: 11/25/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 01	(X3) DATE COMPI		
		155530		LDING		10/16	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LER ST		
SOUTH SHORE HEALTH & REHABILITATION CENTER					IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		occupancies meets the vhen tested in accordance					
	· ·	cited in 10.3.2 (2) and					
	10.3.3. 19.7.5.1						
	Newly introduced	mattresses meet the					
		when tested in accordance					
		ited in 10.3.2 (3), 10.3.4.					
	19.7.5.3						
		ration and interview, the	K0	10074	The facility will ensure that		11/15/2014
	1	ensure decorative			decorative hanging curtains a fire resistant. The decorative	ii C	
	hanging curtains	were rendered flame			hanging curtains that were in		
	resistant in 1 of	5 smoke compartments.			place for a haunted house ha	ve	
	LSC 19.7.5.1 red	quires draperies, curtains,			been removed. No other		
	including cubicle	e curtains, and other			decorative hanging curtains a the facility. Environmental	ire in	
	loosely hanging	fabrics to be in			Director or designee will ensu	ıre	
	accordance with	10.3.1. LSC 10.3.1			that during feature events tha		
	requires draperie	es, curtains, and other			materials used are fire resista		
	similar loosely hanging furnishings and				per policy. The Environmenta		
	decorations to ha	ave flame resistance as			Director or designee will audi materials used in future speci		
	demonstrated by	testing in accordance			events to ensure that all mate		
	with NFPA 701,	Standard Methods of			meet regulation and facility		
	Fire Tests for Fla	ame Propagation of			policy. Results of audits will I		
	Textiles and Filr	ns. This deficient			reported the QA Team on an needed basis.	as	
	practice effects i	residents, visitors, and					
	staff in Units 2 a	and 3 and the main dining					
	room smoke con	npartment.					
	Findings include	: :					
		ration and interview with					
	the maintenance	director on 10/16/14					
	between 11:00 a	.m. and 3:00 p.m., There					
	were two large b	olue plastic tarps hanging					
	from the dining	room ceiling to the floor,					
	which obstructed	d the sprinklers. Each					

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ľ		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED 10/16/2014
155530			B. WING		10/10/2014
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER		LER ST IN 46402	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	tarp was approx 20' x 20' and enclosed an area of approx 20' x 40'. The maintenance director said at the time of observations, that this was temporary for a Halloween haunted house, he did not have evidence of flame resistance or treatment of the blue tarps. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		TAG .		
K010154 SS=C	system is out of see hours in a 24-hour having jurisdiction building is evacual watch system is proportion building is evacual watch system is proportional building is evacual watch system is proportional by the sprinkler system in service. 9.7.6.1 Based on observer staff interview, the provide a written procedures to be the automatic springle placed out-of-serving a 24-hour peril LSC, Section 9.7.	DE STANDARD automatic sprinkler ervice for more than 4 reperiod, the authority is notified, and the ted or an approved fire rovided for all parties left e shutdown until the as been returned to a total policy containing followed in the event rinkler system has to be rovice for 4 hours or more od in accordance with 7.6.1 in order to protect s. LSC 9.7.6.2 requires	K010154	The facility will have written procedures for emergency situations in the building. The policy identified has been upd with procedural steps to take when an emergency happens with the sprinkler system. Oth emergency procedures have been updated to reflect procedural steps to take when emergencies occur. Staff will in-serviced on procedural steps	ated er be

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PRINTED: 11/25/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/16/2014			
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE			
	sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation, record review and interview with the maintenance director on 10/16/14 between 11:00 a.m. and 12:00 p.m., the facility had a document updated in 03/29/10 titled "Fire Watch Policy & Procedure" for a fire protection system failure but did not address all components of LSC Section 9.7.6.1. Specifically, the plan did not include verbiage specifically stating what to do when the sprinkler system for 4 hours or more in a 24 hour period is out of service. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		during an emergency. Policy reviews will be submitted to to QA Team for review. Environmental Director or designee will audit policies at least monthly to ensure that a policies have procedural steps. Results of audits will be reported to the QA Team on on-going basis.	ne all e			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	UMBER: A. BUILDING 01		COMPLETED	
15		155530	B. WING		10/16/2014	
			_	ET ADDRESS, CITY, STATE, ZIP CODE	3	
NAME OF P	ROVIDER OR SUPPLIER	X.		TYLER ST		
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER	GAR	RY, IN 46402		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	OPRIATE CONT ELTTON	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE!)	DATE	
K010155 SS=C	service for more the period, the authorn notified, and the beapproved fire water left unprotected by fire alarm system service. 9.6.1.8 Based on observinterview, the fawritten fire water procedures to be in the event the fire be placed out-off more in a 24-hou with LSC, Section protect 69 of 69 practice could after and visitors. Findings included Based on observinterview with the on 10/16/14 betw 12:00 p.m., the fittled "Fire Water for a fire alarm standards all compared to the period of the period o	fire alarm system is out of han 4 hours in a 24-hour ity having jurisdiction is uilding is evacuated or anoth is provided for all parties by the shutdown until the has been returned to ation, record review and cility failed to ensure its h policy addressed all followed in this facility fire alarm system has to eservice for 4 hours or ar period in accordance on 9.6.1.8 in order to residents. This deficient affect all residents, staff	K010155	The facility will have writted procedures for emergency situations in the building policy identified has been with procedurals to take we emergency happens with sprinkler system. Other emergency procedures has been updated to reflect procedurals to take when emergencies occur. Staff in-serviced on procedural during an emergency. Por eviews will be submitted QA Team for review Environmental Director or designee will audit policies least monthly to ensure the policies have procedural steps. Results of audits wireported to the QA Team on-going basis.	rine updated when an the we will be steps licy to the stat all	
heing out of service for more than 4						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			(X3) DATE SURVEY COMPLETED 10/16/2014		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	hours in a 24 hormaintenance direction aforementioned 3.1-19(b)	ector acknowledged the					

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